Referral Form

Home Health | Palliative Care | Hospice

cascade HEALTH

If you have questions or an urgent need, please call (541) 228-3050.

Referrer Name:_____ Referral Date:_____

Office Contact:_____ Phone:_____

Fill out patient information -OR- place patient sticker here.

Patient Name:_____

DOB:_____

Phone:_____

Insurance:_____

ALL REFERRALS MUST INCLUDE:

- Face Sheet
- Current Medication List
- Recent Chart Notes

Diagnosis:	

ORDERS: Evaluate, admit and treat the above patient if appropriate. (check all that apply)

☐ Home Health Services *Clinical findings support the need for (check all that apply).*	☐ Palliative Care Services *Services below will be included unless otherwise noted.*	☐ Hospice Services *Must have a prognosis of 6 months or less.*
☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Skilled Nursing ☐ Medical Social Worker ☐ Home Health Aid Services needed because:	Provider consultation and symptom management. Advanced care planning. Quality of life plan and discussion. Coordinate care with other providers and community resources. Assistance with medical decisions and treatment. Provide patient and family with emotional, psychosocial and spiritual support/guidance.	☐ In-Home Hospice ☐ Pete Moore Hospice House
Additional information:	Special instructions:	Special instructions:

Ordered by (print MD/DO name):_____ (Required)

Provider Signature_____ Date:_____

PLEASE FAX THIS FORM WITH THE REQUESTED DOCUMENTS TO (541) 228-3182.

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